charges. The next evening he came to the office, but in a different frame of mind. He was full of apologies and with tears in his eyes, confessed that twenty years before he had had syphilis.

In cases like this, when you are yourself doubtful about the character of the disease, it is a serious matter to charge a person with syphilis, and it is, on the other hand, poor medical treatment to let the case pass without the proper advice. It is in such cases a difficult matter to know what to do, to do right.

Dr. G. D. Culver, closing discussion: The paper did what I wanted it to do—it brought out discussion, and I have enjoyed it and profited by it.

Dr. Welty said that he had not had much trouble in diagnosing early lesions of syphilis, such as mucous patches. It is true that they are not so puzzling. Most of the errors I called attention to were with chancre of the mucous membranes and other ulcerated lesions.

Dr. Graham spoke of the ease of diagnosis of lesions above the neck. I do not agree with him. I have seen sarcoma in the roof of the mouth and syphilis in the roof of the mouth, and the picture—as nearly as I could judge—was exactly the same. I think we are inclined to look upon syphilis as fairly easy to diagnose. It is not. We all make mistakes and we are going to continue to make them. I brought up the subject with the idea of calling attention to a few points that should make us a bit more careful. I do not think we should be misled by any laboratory report, whether positive or negative. You may have to deal with a lesion that is not syphilis, yet get a positive Wassermann, and we must consider that there may have been syphilis before, and the positive Wasserman may be the only indication present.

Dr. Spencer called attention to the fact that it might be inferred that I thought cauterization was a good thing. I do not remember ever having cauterized a chancre. We find that the lesions, no matter what they are, react to other treatment better.

I think chancroids must go to the G. U. men; they are very scarce in my work.

The question of considering any lesion which yields to treatment as syphilis, may get one into trouble. There is a skin condition which resembles syphilis and which yields to the iodides, notably sporotrichosis. We also know that blastomycosis, which may easily be mistaken for syphilis, will improve under the iodides. Not many years ago I saw a case of mycosis fungoides which I was determined was syphilis. Every test was negative, treatment was negative; after following the case for a number of months I came to the conclusion it was mycosis fungoides, and it proved to be that disease.

It is so easy to err in the diagnosis of syphilis, so difficult not to do so, that any discussion such as we have had should be of marked benefit.

THE LATE CORRECTION OF MAL-UNITED FRACTURES OF THE EXTREMITIES.*

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The treatment of fractures has received so much attention in the last few years, and the progress made in this branch of surgery has been so great, that it seems as though a bad result should now be a thing of the past; and yet, for reasons to be stated below, it appears that mal-union still occurs in a large number of cases. It goes without saying that the best anatomical and functional result should always be our aim, but this ideal is not attained at all times and the fact remains that even nowadays the primary treatment of many fractures often results in disaster.

The causes for the failures are many; some cases are difficult to diagnose, others present extraordinary obstacles to treatment even in the hands of the best surgeons, while tardy consolidation and anomolies in callus-formation, such as exuberant callus near an articulation or a deficient callus, at times determine an unfavorable result. But in most cases the harm is due to the fact that the fracture has to be treated by a man who does not have adequate facilities for the work, although the doctor is not always the one to blame for embarking in such a risky enterprise; we all know how difficult it is to persuade patients in outlying districts to leave their homes and go to the city for treatment.

To the doctor who admits that he is not properly equipped, the patients, even well-to-do persons who do not need to consider the expense, will answer that they will be satisfied with any kind of a result provided they do not have to leave their homes; this sounds very nice, but the same people who exert such pressure on their physicians and influence them to assume the responsibility for treatment of the case are the first to criticize him mercilessly and even to threaten to sue for damages in the event of a faulty union, and are without any regard for the man who has done his level best under adverse circumstances to please and to help them.

Let us follow the course of a typical case of this kind. By this time six or eight weeks have elapsed since the accident and the failure becomes every day more apparent to the doctor and also to the patient. This is the very time when prompt decision and energetic action are in place to prevent the patient from regarding the result as final and to persuade him that an important correction is still possible and necessary; but, curiously enough, a period of discouragement and inertia sets in during which both the surgeon and the patient seem loath to undertake anything definite, and nothing is done for a long time. To point out that there is still much room for progress in this direction and to call the attention of the medical profession to the great loss of time and working capacity entailed by such a course is the object of this paper.

In cases of this kind that have come to me for final correction I have often noted that four, six, eight, and even ten months have been permitted to elapse after the original injury before a surgical procedure would be proposed and accepted; during all this time the patient remained disabled and in a crippled condition. Many of them were unable to walk, and one, a young lady with a fracture near the elbow, was for months unable to dress alone; this patient had a supra condylar fracture of the humerus combined with posterior displacement of the inferior fragment in such a way that flexion was impossible. This was allowed to continue for four months before she came for an osteotomy of the humerus.

Again, a boy with a simple malleolar fracture was kept in a cast without any attention being

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paid to the equinus position of the foot; for nearly five months he was left to hop around with a bad ankylosis before he was sent for surgical treatment. It was impossible to break the ankylosis even under an anaesthetic, and a resection of the tibio-tarsal joint was necessary in order to restore sufficient motion. In another case a young man was left in a cast with his foot in a marked equinus position and nothing was done until it was finally realized seven months after the accident that he would never walk with that stiff joint.

A man with a fracture of the femur that had healed with great shortening, and also with the left elbow ankylosed in full extension, waited nearly four months before he came for an osteotomy of the femur and an arthroplasty of the elbow. Another man with a false joint, pseudoarthrosis, of the femur, came to me for a bonegraft operation as late as ten months after the accident. These are only a few that I have actually witnessed, but I have heard of many similar occurrences and in some of them the length of time so wasted has been incredibly long.

It is clear that such great delay in resorting to rational surgical treatment results in a prolonged and unnecessary period of total disability as it could nearly always be either avoided or much shortened.

The attitude of insurance companies toward such delays is surprising; the same insurance companies that are very strict with independent surgeons raise no objection when their own men for a relatively simple fracture keep the patient in hospital six, eight, or ten months, or more.

At all events, whatever may be the cause for such great delay in resorting to surgical treatment in this class of cases, whether discouragement, pessimism, or mental inertia, the attitude of the medical profession in relation to further and more active treatment does not seem justified, and is to be deplored. Sad as it is to experience a check in the primary treatment of a fracture, we should never forget that the resources of surgery are great and that the results of secondary orthopedic operations for mal-united fractures especially are very gratifying.

Of course it is always better, if possible, to prevent faulty union; but granting that a bad result could not be avoided and perhaps becomes firmly established, the situation is very much like that of a ship in danger of sinking through some mistake or misfortune due to its officers; even in this extremity it is the duty of the captain, not to remain idle, but to handle his vessel in such a manner as to save as much as possible from the wreck. The surgery of mal-united fractures is also salvage surgery, but it is well worth trying to do. For here also, when everything seems lost and all hope has been abandoned, a well planned orthopedic intervention and judicious after-treatment will often save a surprising amount of function for the patient, and this should be welcome news to a man already in fear that he will remain a cripple.

Another reason why the medical profession should avoid delay and should avail itself promptly of the help of surgery in mal-united fractures arises from the frequent threats of malpractice suits which seem to have become daily occurrences. If the physician after treating a fracture six weeks or two months finds the result unsatisfactory, then temporizes and hesitates several more weeks or months, the patient will gain the impression that the treatment is ended, and realizing eventually that the bad result is a consequence of the treatment, the next thing that will come into his mind will be a suit for damages.

If, on the contrary, the physician himself on recognizing after a few weeks that the result is not good, would declare without any hesitation to the patient that the union is not what it should be, that this occasionally happens in the treatment of fractures, and that the necessary correction can be assured only by an operation, the patient would realize that the treatment was not concluded, that there had been only a delay, and that what must next take place was merely a continuation of the cure. This would immediately shut the door to any intention to start a malpractice suit, for it would be clear that no one could be held responsible for a treatment which had not yet been completed.

Therefore if these cases are recognized early, handled with decision, and submitted promptly to operative intervention, much would be gained for the reputation and peace of mind of the physician attending, as well as for the welfare of the patient. In this field we have at our command many procedures and interventions which can only be mentioned briefly here, such as removal of interposed muscles and fascias, freeing of compressed nerves, osteotomies, bonegraft operations, occasional wiring, and resection or arthroplasty; some one or other of these methods may often sufficiently improve conditions to give the patient a useful limb.

CONCLUSIONS.

1. From circumstances independent of the will of the surgeon, many fractures conscientiously treated by the ordinary methods result in malunion and in impaired function, making necessary some surgical intervention.

2. Owing to undue pessimism and discouragement of both the patient and his attending physician, the time elapsing between the accident and the decision to submit to final operative correction is much too great and often as a rule keeps the patient several months unnecessarily in a condition of total disability.

3. This pessimism is wholly unjustified as the secondary correction of mal-united fractures is yielding very good results and should be resorted to as promptly as possible.

4. If, in cases with a bad result, instead of a long interruption in treatment the necessary correction were immediately recommended at an early date the patient would believe this to be a mere continuance of the cure, and this itself would go a long way to check any idea of starting malpractice proceedings.